Office of the Registrar of Regulations,
Legislative Council,
State of Delaware

DEPARTMENT OF INSURANCE

OFFICE OF THE COMMISSIONER

Statutory Authority: 18 Delaware Code, Sections 311, 3349, 3565 and 6408
(18 **Del.C.** §§311, 3349, 3565 & 6408)

PROPOSED

PUBLIC NOTICE

1316 Arbitration of Health Insurance Disputes Between Carriers And Non-Network Providers of Emergency Care Services

INSURANCE COMMISSIONER KAREN WELDIN STEWART hereby gives notice of proposed Department of Insurance **Regulation 1316** relating to **Arbitration of Health Insurance Disputes Between Carriers And Non-Network Providers of Emergency Care Services**. The docket number for this proposed regulation is 3002.

The proposed regulation moves the provisions related to arbitrations under 18 **Del.C.** §§3349 and 3565 from current Regulation 1301 to a stand-alone regulation. The Delaware Code authority for this proposed regulation is 18 **Del.C.** §§311, 3349, and 3565; and 29 **Del.C.** Ch. 101.

The Department of Insurance does not plan to hold a public hearing on the proposed regulation. The proposed regulation appears below and can also be viewed at the Delaware Insurance Commissioner's website at http://www.delawareinsurance.gov/departments/documents/ProposedRegs/.

Any person can file written comments, suggestions, briefs, and compilations of data or other materials concerning the proposed regulation. Any written submission in response to this notice and relevant to the proposed regulation must be received by the Department of Insurance no later than 4:30 p.m. EST, Monday, February 1, 2016. Any such requests should be directed to:

Regulatory Specialist Rhonda West
Delaware Department of Insurance
841 Silver Lake Boulevard
Dover, DE 19904
Phone: (302) 674-7379
Fax: (302) 739-5566
Email: rhonda.west@state.de.us

1316 Arbitration of Health Insurance Disputes Between Carriers And Non-Network Providers of Emergency Care Services

1.0 Purpose and Statutory Authority

The purpose of this Regulation is to implement 18 **Del.C.** §§3349 and 3565, which require the Delaware Insurance Department to establish and administer procedures for arbitration of disputes between health insurance carriers and non-network providers of emergency care services. This Regulation is promulgated pursuant to 18 **Del.C.** §§311, 3349, and 3565; and 29 **Del.C.** Ch. 101. This Regulation should not be construed to create any cause of action not otherwise existing at law.

2.0 Definitions

"**Carrier**" means any entity that provides health insurance in this State. Carrier includes an insurance company, health service corporation, managed care organization and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation. Carrier also includes any third-party administrator or other entity that adjusts, administers or settles claims in connection with health insurance.

"**Covered person**" means an individual and/or family who has entered into a contractual arrangement, or on whose behalf a contractual arrangement has been entered into, with a carrier, pursuant to which the carrier provides health insurance for such person or persons.

"**Department**" means the Delaware Insurance Department.

"**Duration of an Emergency Medical Condition**" means a period of time that begins with an Emergency Medical Condition and ends when the Emergency Medical Condition is either treated or stabilized as such stabilization is evidenced by post stabilization care, as referenced in 18 **Del.C.** §§3349(d)(3) and 3565(d)(3), in a hospital where such post stabilization care is not within the definition of emergency care services.

"**Emergency care provider**" means a provider of emergency care services including a provider who also provides health care services that aren't emergency care services.

"**Emergency care services**" means those services identified in 18 **Del.C.** §§3349(d) and 3565(d) performed at any time during the Duration of an Emergency Medical Condition, including any covered service providing for the transportation of a patient to a hospital emergency facility for an emergency medical condition including air and sea ambulances so long as medical necessity criteria are met.

"**Emergency Medical Condition**" shall have the meaning assigned to it by 18 **Del.C.** §§3349(e) and 3565(e).

"**Health care services**" means any services or supplies included in the furnishing to any individual of medical care or hospitalization, or incidental to the furnishing of such care or hospitalization, as well as the furnishing to any individual of any and all other services for the purpose of preventing, alleviating, curing or healing human illness, injury, disability or disease.

"**Health insurance**" means a plan or policy issued by a carrier for the payment for, provision of, or reimbursement for health care services.

"**Network carrier**" is a carrier that has a written participation agreement with a provider to pay for emergency care services.

"**Network Emergency Care Provider**" is a provider who has a written participation agreement with the carrier to provide emergency care services or governing payment of emergency care services.

"**Non-Network Emergency Care Provider**" is a provider who is not a Network Emergency Care Provider.

"**Provider**" means an individual or entity, including without limitation, a licensed physician, a licensed nurse, a licensed physician assistant and a licensed nurse practitioner, a licensed diagnostic facility, a licensed clinical facility, and a licensed hospital, who or which provides health care services in this State.

3.0 Provisions Applicable to Arbitration Pursuant to 18 Del.C. §§3349 and 3565

3.1 If a carrier and a non-network emergency care provider cannot agree on payment to the provider for emergency care services, within 30 days after the carrier has received from the provider clean claims, as defined in Section 4.0 of Regulation 1310, for such services, either the carrier or the non-network emergency care provider (the "Petitioner") may petition for arbitration pursuant to this Section 3.0 and 18 **Del.C.** §§3349 or 3565 and the other party (the "Respondent") shall submit to such arbitration.

3.2 Prior to the Arbitration Hearing, the Arbitrator shall at a minimum receive the following written evidence from the parties:

3.2.1 The highest allowable charge for each emergency care service subject to arbitration allowed by the carrier for any other network or non-network emergency care provider during the full twelve month period immediately prior to the date the Petition for Arbitration was filed with the Department;

3.2.2 If subsection 3.4.1 applies, the carrier's highest allowable charge for each emergency care service subject to arbitration pursuant to the non-network provider's most recent participation agreement with the carrier;

3.2.3 The highest allowable charge for each emergency care service subject to arbitration received by the non-network emergency care provider from any other carrier during a full twelve month period immediately prior to the date the Petition for Arbitration was filed with the Department; and

3.2.4 The highest allowable charge for each emergency care service subject to arbitration received by the non-network emergency care provider from any network carrier during a full twelve month period immediately prior to the date the Petition for Arbitration was filed with the Department.

3.2.5 Each party shall also submit in writing the allowable charge each party would accept for each emergency care service subject to arbitration and each party's history of the negotiations between the parties relating to each such emergency care service.

3.2.6 Each party shall also submit a written list of all emergency care services subject to arbitration and the date each service was delivered to the patient. The Arbitrator's decision shall apply to each such service from the date of each service and the date of all other emergency care service subject to arbitration through the date provided for in subsection 3.12.2.

3.2.7 A copy of all information submitted to the Arbitrator by a party pursuant to this Section 3.0 will also be given to the other party except for information submitted by the provider pursuant to subsections 3.2.3 and 3.2.4. subsection 3.2.3 and subsection 3.2.4 information will be redacted by the Arbitrator and given to the carrier to insure that the carrier cannot determine pricing information relating specifically to other carriers.

3.3 All information specified in subsection 3.2 of this Regulation provided to the Arbitrator shall presumptively be considered trade secret or confidential financial information under the Delaware Freedom of Information Act and shall not be disclosed to or available at any time to any person, firm or entity not involved in the arbitration.

3.4 The Arbitrator shall follow the guidelines listed in this subsection 3.4 as a basis for determining the carrier's payment to the non-network emergency care provider for each emergency care service subject to arbitration unless the evidence adduced at arbitration supports a different payment.

3.4.1 Payments for emergency care services to a non-network emergency care provider who was a network emergency care provider at any time prior to the date the provider delivered the emergency care services which are the subject of the arbitration. The Arbitrator shall direct the carrier to pay the non-network emergency care provider based on an allowable charge for each emergency care service subject to arbitration within the following range: (1) the allowable charges submitted to the Arbitrator pursuant to subsection 3.2.2, subject to COLA adjustments as may be published in bulletins by the Commissioner from time to time; and (2) the allowable charges submitted to the Arbitrator pursuant to subsection 3.2.3. All payments pursuant to this section are subject to reduction based on the insured's obligations for co-payments or deductibles.

3.4.2 Payments for emergency care services to a provider who was never a network emergency care provider with the carrier. The Arbitrator shall direct the carrier to pay the non-network emergency care provider who was never a network emergency care provider based on an allowable charge for each emergency care service subject to arbitration within the following range: (1) the allowable charges submitted to the carrier pursuant to subsection 3.2.1; and (2) the allowable charges submitted to the Arbitrator pursuant to subsection 3.2.3. All payments pursuant to this section are subject to reduction based on the insured's obligations for co-payments or deductibles.

3.5 Changes in the membership of a provider group will not affect the remaining group member(s) insofar as the application of this Section 3.0. In the absence of a contract provision to the contrary, a physician's existing network status and payment rights shall not be transferable to that physician's new group or practice.

3.6 Carrier Payments Prior to Arbitration.

3.6.1 Prior to Arbitrator's decision pursuant to subsection 3.12, the carrier will pay directly to the non-network emergency care provider the highest amount provided for in subsection 3.2.1 for each emergency care service subject to arbitration.

3.6.2 All payments due the non-network provider pursuant to subsection 3.6.1 will be paid within 30 days after the carrier has received from the provider a clean claim, as defined in Section 4.0 of Regulation 1310, for each emergency care service subject to arbitration.

3.6.3 The Arbitrator will direct the carrier and the provider to pay, in the case of the carrier, or refund in the case of the provider, the difference between payments made pursuant to this subsection 3.6 and the payments determined by the Arbitrator pursuant to subsection 3.4.

3.7 Procedures for Arbitration Pursuant to this Section 3.0.

3.7.1 Either the non-network emergency care provider or his authorized representative or the carrier, after the carrier pays the provider pursuant to subsection 3.6.1, may request arbitration by delivering to the Department an original and one copy of the Petition for Arbitration, (with all applicable information required by subsection 3.2 attached) so that the Petition is received by the Department no later than 60 days from the date the carrier was required to pay the provider pursuant to subsection 3.6.1.

3.7.2 At the time of delivering the Petition for Arbitration to the Department. the Petitioner or his authorized representative must also:

3.7.2.1 send a copy of the Petition and supporting documentation to the Respondent by certified mail, return receipt requested, except as provided by subsection 3.2.7;

3.7.2.2 deliver to the Department a Proof of Service confirming that a copy of the Petition has been sent to the Respondent by certified mail, return receipt requested; and

3.7.2.3 deliver to the Department a $75.00 filing fee.

3.7.3 The Department may refuse to accept any Petition that is not timely filed or does not otherwise meet the criteria for arbitration.

3.8 Response to Petition for Arbitration

3.8.1 Within 20 days of receipt of the Petition, the Respondent or his authorized representative must deliver to the Department an original and one copy of a Response with all information required by subsection 3.2 attached.

3.8.2 At the time of delivering the Response to the Department, the Respondent must also:

3.8.2.1 send a copy of the Response and supporting documentation to the Petitioner or his authorized representative by certified mail, postage prepaid, except as provided by subsection 3.2.7; and

3.8.2.2 deliver to the Department a Proof of Service confirming that a copy of the Response was mailed to the Petitioner or his authorized representative.

3.8.3 The Department may return any non-conforming Response to Respondent.

3.8.4 If the Respondent fails to deliver a Response to the Department in a timely fashion, the Department, after verifying proper service, and with written notice to the parties, may assign the matter to the next scheduled Arbitrator for summary disposition.

3.8.4.1 The Arbitrator may determine the matter in the nature of a default judgment after establishing that the Petition is properly supported and was properly served on the Respondent.

3.8.4.2 The Arbitrator may allow the re-opening of the matter to prevent a manifest injustice. A request for re-opening must be made no later than seven days after notice of the default judgment.

3.9 Summary Dismissal of Petition by the Arbitrator

3.9.1 If the Arbitrator determines that the subject of the Petition is not appropriate for arbitration, the Arbitrator may summarily dismiss the Petition and provide notice of such dismissal to the parties.

3.10 Appointment of Arbitrator

3.10.1 Upon receipt of a proper Response, the Department shall assign an Arbitrator who shall schedule the matter for a hearing so that the Arbitrator can render a written decision within 45 days of the delivery to the Department of the Petition for Arbitration.

3.10.2 The Arbitrator shall be of suitable background and experience to decide the matter in dispute and shall not be affiliated with any of the parties.

3.11 Arbitration Hearing

3.11.1 The Arbitrator shall give notice of the arbitration hearing date to the parties at least 10 days prior to the hearing. The parties are not required to appear and may rely on the papers delivered to the Department.

3.11.2 The arbitration hearing is to be limited, to the maximum extent possible, to each party being given the opportunity to explain their view of the previously submitted evidence and to answer questions by the Arbitrator.

3.11.3 If the Arbitrator allows any brief testimony, the Arbitrator shall allow brief cross-examination or other response by the opposing party.

3.11.4 The Delaware Uniform Rules of Evidence will be used for general guidance but will not be strictly applied.

3.11.5 Because the testimony may involve evidence relating to personal health information that is confidential and protected by state or federal laws from public disclosure, the arbitration hearing shall be closed.

3.11.6 The Arbitrator may contact, with the parties' consent, individuals or entities identified in the papers by telephone in or outside of the parties' presence for information to resolve the matter.

3.11.7 The Arbitrator is to consider the matter based on the submissions of the parties and information otherwise obtained by the Arbitrator in accordance with this Section 3.0. The Arbitrator shall not consider any matter not contained in the original or supplemental submissions of the parties that has not been provided to the opposing party with at least five days notice, except claims of a continuing nature that are set out in the filed papers.

3.12 Arbitrator's Written Decision.

3.12.1 The Arbitrator shall render his decision and mail a copy of the decision to the parties within 45 days of the filing of the Petition.

3.12.2 The Arbitrator's decision is binding upon the parties with respect to allowable charges and payments for each emergency care service subject to arbitration for a period that will end on the 360th day after the date of the Arbitrator's decision.

3.13 Arbitration Costs.

3.13.1 The non-prevailing party at arbitration shall reimburse the Commissioner for the expenses related to the arbitration process.

3.14 Arbitrations subject to this Regulation 1316 shall not be subject to the provisions of Regulation 1313.

3.15 Exemption from Arbitration. 18 **Del.C.** §§3349(b) and 3565(b) shall not apply to health insurance policies exempt from state regulation under federal law or regulation. On a quarterly basis, each carrier shall provide a list of exempt plan numbers to the Department. The Department shall maintain a public register of exempt plan numbers. The placement of an exempt plan number on the register shall constitute a rebuttable presumption that the policy plan is not subject to the provisions of this regulation. A carrier that clearly identifies whether a plan is either exempt or non-exempt on the face of an identification or membership card shall not be required to comply with the provisions of this section but only with respect to the plans for which such identification or membership cards display the group status. The failure of a carrier to either (1) provide the Department with a list of exempt plan numbers, or (2) clearly identify if a plan is exempt or non-exempt on the face of an identification or membership card shall constitute a rebuttable presumption that the plan is subject to the provisions of this regulation.

3.16 A carrier and a non-network emergency care provider can mutually agree in writing to submit to arbitration pursuant to Section 3.0 payment disputes relating to the delivery of emergency care services to patients covered by a plan otherwise exempt from arbitration, except that such agreement will only apply to the plan and the services stated therein.

3.17 The provisions of this regulation shall not apply to Medicaid or any other health insurance program where the review of coverage determinations is otherwise regulated by the provisions of other state or federal laws or regulations.

4.0 Confidentiality of Health Information

Nothing in this Regulation shall supersede any federal or state law or regulation governing the privacy of health information.

5.0 Computation of Time

In computing any period of time prescribed or allowed by this Regulation, the day of the act or event after which the designated period of time begins to run shall not be included. The last day of the period so computed shall be included, unless it is a Saturday or Sunday, or other legal holiday, or other day on which the Department is closed, in which event the period shall run until the end of the next day on which the Department is open. When the period of time prescribed or allowed is less than 11 days, intermediate Saturdays, Sundays, and other legal holidays shall be excluded in the computation. As used in this section, "legal holidays" shall be those days provided by statute or appointed by the Governor or the Chief Justice of the State of Delaware.

6.0 Effective Date

This Regulation shall become effective ten days after being published as a final regulation.

19 DE Reg. 573 (01/01/16) (Prop.)